



State of Utah

SPENCER J. COX  
*Governor*

DEIDRE M. HENDERSON  
*Lieutenant Governor*

## Department of Human Services

TRACY S. GRUBER  
*Executive Director*

Division of Substance Abuse and Mental Health  
DOUG THOMAS  
*Director*

March 15, 2021

Commissioner Lorene Miner Kamalu  
Davis County Commission  
PO Box 618  
Farmington, UT 84025

Dear Commissioner Kamalu:

In accordance with Utah Code Annotated 62A-15-103, the Division of Substance Abuse and Mental Health has completed its annual review of Local Authority, Davis County and Davis Behavioral Health, its contracted service provider; the final report is enclosed. The scope of the review included fiscal management, children, youth, family and adult mental health services, substance abuse treatment and prevention services, and general operations.

The center has many strengths; however, this report by its nature focuses on the exceptions and areas in need of improvement. The Division has approved all corrective action plans submitted by the Center/County in response to each reported finding, which have been included in the final report. If you have any questions, please contact Kelly Ovard at 385-310-5118.

We appreciate the cooperation and assistance of the staff and look forward to a continued professional relationship.

Sincerely,

A handwritten signature in blue ink, appearing to read "D. P. Thomas".  
Doug Thomas (Mar 15, 2021 16:11 MDT)

Doug Thomas  
Division Director

Enclosure

cc: Commissioner Bob Stevenson, Davis County Commission  
Commissioner Randy Elliott, Davis County Commission  
Brandon Hatch, Director of Davis Behavioral Health



Site Monitoring Report of

Davis Behavioral Health

Local Authority Contracts #160072 and #160073

Review Date: December 8th, 2020

Final Report

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## **Section One: Site Monitoring Report**

## **Executive Summary**

In accordance with Utah Code Section 62A-15-103, the Division of Substance Abuse and Mental Health (also referred to in this report as DSAMH or the Division) conducted a review of Davis County and their contracted service provider, Davis Behavioral Health (also referred to in this report as DBH or the Center) on December 8th, 2020. The focus of the review was on governance and oversight, fiscal management, pediatric and adult mental health services, substance abuse prevention and treatment services and general operations.

The nature of this examination was to evaluate the Center's compliance with: State policies and procedures incorporated through the contracting process; Division Directives; State mandated mental health services; and Preferred Practice Guidelines. During the examination, the review teams evaluated: the reliability and integrity of the Center's data and its compliance with established programmatic and operational objectives. Additionally, the review included an examination, through sampling, of the Center's efficient and appropriate use of financial resources.

Any program or operational inadequacies are identified in this report as non-compliance issues. The chart on the following page provides a quick reference to locate any non-compliance issues identified by the monitoring team. A detailed description of the issues can be found in the body of this report.

The Center is required to respond in writing within 15 business days of this draft report with a plan of action addressing each non-compliance issue and the Center employee responsible to ensure its completion.

## Summary of Findings

<b>Programs Reviewed</b>	<b>Level of Non-Compliance Issues</b>	<b>Number of Findings</b>	<b>Page(s)</b>
<i><b>Governance and Oversight</b></i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None None	
<i><b>Child, Youth &amp; Family Mental Health</b></i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None None	
<i><b>Adult Mental Health</b></i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None 1	14-15
<i><b>Substance Abuse Prevention</b></i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None 1	19
<i><b>Substance Abuse Treatment</b></i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None 3 None	22-23

## **Governance and Fiscal Oversight**

The Division of Substance Abuse and Mental Health (DSAMH) conducted its annual monitoring review of the Local Authority, Davis County, and its contracted service provider, Davis Behavioral Health (DBH). The Governance and Fiscal Oversight section of the review was conducted on December 8 and December 16, 2020 by Kelly Ovard, Financial Services Auditor IV.

A site visit and review was conducted remotely, due to the Covid-19 pandemic, with DBH as the contracted service provider for Davis County. Davis County also provided documentation for their annual review of DBH. Overall cost per client data was analyzed and compared to the statewide Local Authority average. Personnel and subcontractor files were examined for compliance with state licensing laws and adherence to contractual requirements, as well as the Center's own policy. Executive travel reimbursements were reviewed to ensure they were appropriate and that no personal benefit has been gained. Board minutes were reviewed and discussions were conducted to determine if an appropriate level of involvement and financial oversight was provided.

As part of the site visit, DBH provided backup to support their costs and billed amounts, using rates taken from their Medicaid Cost Report. This report is a cost study conducted by the Local Authority and then reviewed/approved by the Department of Health (DOH), Medicaid Division. This report establishes the center's cost allocation plan as it pertains to overhead/administrative costs and spreads these costs across the Current Procedural Terminology (CPT) billing codes used by the Center that year. This allows the Division to fairly incorporate these overhead/administrative costs into the payments sent for services that qualify for funding found on the Center's contract allocation letter. Random samples were taken from the backup provided to verify that the listed services qualified for each different service category.

The Local Authority, Davis County received a single audit as required. The CPA firm Ulrich & Associates, PC completed the audit for the year ending December 31, 2019. The auditors issued an unmodified opinion in their report dated June 25th, 2020. The SAPT Block Grant was selected for specific testing as a major program. No findings or deficiencies were issued in the audit.

Davis Behavioral Health, the contracted service provider for Davis County, also received a single audit. The CPA firm Litz & Company completed the audit for the year ending June 30, 2020. The auditors issued an unmodified opinion in their report dated September 29, 2020. The STR Opioid Crisis Grant was selected for specific testing as a major program. No findings or deficiencies were issued.

### **Follow-up from Fiscal Year 2020 Audit:**

#### **FY20 Deficiencies:**

- 1) *Federal Awards Policy* - The OMB Uniform Guidance under 2 CFR 200 requires non-Federal entities that receive Federal funding to have a written policy surrounding the management of their Federal award funds. Davis County does not currently have an approved Federal awards policy in place.

*This issue has been resolved. Davis County provided it's Federal Awards Policy. In FY21 it will be a recommendation for DBH to develop its own Federal Awards Policy.*

- 2) During the review of personnel files, several BCI background screenings were found to be expired. The Office of Licencing (OL) has a new system for processing these and has had some issues with approving them timely. A check was done with OL and most were showing as being processed, but there was one that had expired in April of 2019 and had not been submitted by DBH.

*This issue has been resolved. DOPL has a new system which shows employees as Eligible.*

### **Findings for Fiscal Year 2021 Audit:**

#### **FY21 Major Non-compliance Issues:**

None

#### **FY21 Significant Non-compliance Issues:**

None

#### **FY21 Minor Non-compliance Issues:**

None

#### **FY21 Deficiencies:**

None

#### **FY21 Recommendations:**

- 1) **Timeliness of receiving Financial Services Data.** The data for financial services audit should be complete and provided by the date of the G&O audit meeting.
- 2) **The DBH emergency plan** was reviewed by Robert Snarr, Program Administrator and Geri Jardine, Program Support Specialist, as part of the site visit. A checklist based on SAMHSA

recommendations was completed and is included at the end of this report as Attachment A. It is recommended that DBH review these suggestions and update their emergency plan



accordingly. DSAMH is available for technical assistance. **Please review the plan and correct the 15 non-compliance issues.**

- 3) It is recommended that DBH develop its own **Federal Awards Policy**.

**FY21 Division Comments:**

- 1) The audit information that was provided was clear and included the provider's Medicaid Cost Report, which was greatly appreciated.

## **Mental Health Mandated Services**

According to Utah Code 17-43-301, the Local Authority is required to provide the following ten mandated services:

Inpatient Care

Residential Care

Outpatient Care

24-hour Emergency Services

Psychotropic Medication Management

Psychosocial Rehabilitation (including vocational training and skills development)

Case Management

Community Supports (including in-home services, housing, family support services, and respite services)

Consultation and Education Services

Services to persons incarcerated in a county jail or other county correctional facility

The mandate to provide services to those in county correctional facilities is not applicable to the children and youth population.

In subsection (4)(a)(ii) each local authority is required to “annually prepare and submit to the Division a plan approved by the county legislative body for mental health funding and service delivery, either directly by the local mental health authority or by contract.” This annual area plan provides the state Division of Substance Abuse and Mental Health with a measuring tool against which the local authority is measured during the annual monitoring site review.

A major focus of the monitoring efforts of the Division of Substance Abuse and Mental Health is to measure compliance with this legislative mandate to provide these services to the adults, youth, and children of Utah.

## **Child, Youth and Family Mental Health**

The Division of Substance Abuse and Mental Health Children, Youth, & Families team conducted its annual monitoring review at Davis Behavioral Health on December 8 and 9, 2020. Due to COVID-19, the annual monitoring review was held virtually. The monitoring team consisted of Leah Colburn, Program Administrator; Mindy Leonard, Program Manager; Tracy Johnson, Wraparound and Family Peer Support Program Administrator; and Heather Rydalch, Peer Support Program Manager. The review included the following areas: discussions with clinical supervisors and management, record reviews, program visits, and allied agency visits. During the discussion the team reviewed the FY20 audit, statistics, including the Mental Health Scorecard, Area Plans, Youth Outcome Questionnaires, Family Resource Facilitation (Peer Support), High Fidelity Wraparound, school based behavioral health and compliance with Division Directives and the center's provision of the ten mandated services as required by Utah Code 17-43-301.

### **Follow-up from Fiscal Year 2020 Audit**

No findings were issued for FY20.

### **Findings for Fiscal Year 2021 Audit**

#### **FY21 Major Non-compliance Issues:**

None

#### **FY21 Significant Non-compliance Issues:**

None

#### **FY21 Minor Non-compliance Issues:**

None

#### **FY21 Deficiencies:**

None

#### **FY21 Recommendations:**

- 1) *Holistic Approach to Health:* During the review of their assessments there is minimal documentation identifying a client's primary care physician and supporting conversations about physical health wellbeing. Ensuring that youth have an identified provider and access to physical healthcare is a key metric for a child's overall health and wellbeing. It is recommended that DBH provide training to staff to include the documentation of this type of information, including during assessment and case management activities to encourage conversation about healthcare access and appropriate linkages to physical health care providers, including dental and vision, for children. It is noted that DSAMH and DBH discussed this at the FY20 monitoring visit. During this visit, DBH noted that they were not able to establish a clearer holistic approach to children's health, due to service priorities stemming from the pandemic, and it remains a recommendation.
- 2) *Respite:* DBH continues to provide respite services at a lower rate than the urban average (FY19 132 clients/5.4%, FY20 112 clients/4.3%), for the second year. While DSAMH

recognizes that COVID-19 may have had an impact in providing this service, DBH should explore avenues to provide respite services to more youth and families, when appropriate.

- 3) *Psychosocial Rehabilitation*: DBH continues to provide psychosocial rehabilitation services at a lower rate than the urban average (FY19 193/7.9% FY20 165/6.4%), for a second year in a row. While DSAMH recognizes that COVID-19 may have had an impact in providing this service, DBH should explore avenues to provide psychosocial rehabilitation services to more youth and families, when appropriate.

**FY21 Division Comments:**

- 1) *Family Resource Facilitation and Family Peer Support*: DBH had a decrease in families served with family peer support services (FY19 424 families, FY20 354 families). DSAMH recognizes that COVID-19 may have impacted this service provision. It is encouraged to review this service and data collection methods to identify and rectify barriers in order to increase access to this service for youth and families. It is encouraged to explore FPS groups and school based peer support as an avenue to increase access. It is also recommended to review referral and funding pathways both internally and with community partners to increase the number of families served at the center.
- 2) *Juvenile Receiving Center and the Division of Juvenile Justice Services*: DBH recently partnered with the Division of Juvenile Justice Services (DJJS) as they opened a new juvenile receiving center at Farmington Bay. DBH provides a full time behavioral health therapist at this location to provide clinical services and support at the receiving center. DJJS is also able to access Stabilization and Mobile Response and other crisis services during off hours and weekends. Youth who are served through the juvenile receiving center are also referred to services through DBH or a third party provider once they transition home. The partnership highlights DBH's commitment to engage with community partners to expand programming in the community and ensure youth and their families have increased access to behavioral health care.
- 3) *Access to services*: DSAMH commends DBH for being able to increase the number of youth clients in their programs over this state fiscal year (FY19 2,461 to FY20 2,589). DBH has been creative in finding opportunities to expand and maintain services to youth over FY20 including utilization of wraparound programming, developing programming to meet the clients current needs including short term treatment groups, expanding the use of evidence based practices amongst their providers for youth, and engagement with community partners to support family needs. Creative solutions are integral to ensuring youth and their families are being served, especially during the COVID-19 pandemic.
- 4) *Agency Resilience*: DBH has had a number of program leadership changes over the past year. It was identified that due to retirement and a small amount of turnover, nearly all of the mental health program leads are new since the prior monitoring year. DBH has been able to

provide high quality programs while continuing to expand programming for youth and families in the midst of new program leaders.

## **Adult Mental Health**

The Division of Substance Abuse and Mental Health Adult Mental Health team conducted its annual monitoring review at Davis Behavioral Health (DBH) on December 8 and 9, 2020. Due to COVID-19, the annual monitoring review was held virtually. The monitoring team consisted of Mindy Leonard, Program Manager; Leah Colburn, Program Administrator; Pam Bennett, Program Administrator; and Heather Rydalch, Peer Support Program Manager. The review included the following areas: discussions with clinical supervisors and management, record reviews, program visits, and allied agency visits. During the discussion the team reviewed the FY20 audit, statistics, including the Mental Health Scorecard, Area Plans, Outcome Questionnaires, compliance with Division Directives and the center's provision of the ten mandated services as required by Utah Code 17-43-301.

### **Follow-up from Fiscal Year 2020 Audit**

None

### **Findings for Fiscal Year 2021 Audit**

#### **FY21 Major Non-compliance Issues:**

None

#### **FY21 Significant Non-compliance Issues:**

None

#### **FY21 Minor Non-compliance Issues:**

None

#### **FY21 Deficiencies:**

- 1) *Administration and Clinical Use of the Outcome Questionnaire (OQ):* Division Directives require at least 50% administration rate to clients served. The FY21 Adult Mental Health Scorecard indicates that administration rates have decreased to 49.5%, falling below the required rate for the third time in five years. Division Directives also state that “*data from the OQ or YOQ shall be shared with the client and incorporated into the clinical process, as evidenced in the chart.*” Eight of the nine charts reviewed did not demonstrate use of the OQ as a clinical tool. Of note, one of the nine charts was for a client receiving medication management only. DBH has indicated that OQ administration and clinical use will be a clinician initiative moving forward.

Not including the OQ in telehealth sessions is a concern due to lack of measurable outcomes. This may be an overall concern within the Local Mental Health Authority system as there are more sessions held through a virtual platform. It is recommended that DBH work in conjunction with other clinical directors and DSAMH to develop a process for administering and documenting the use of the OQ with telehealth-provided services.

## County's Response and Corrective Action Plan:

**Action Plan:** Each clinician is going to be trained on how to send the OQ link via email to their clients. This will allow for the OQ to be completed prior to the session. Each clinician will be given a printed copy of their schedules each week asking them to mark off who received the OQ and then at the end of the week return it to their supervisor. We will be asking for the OQ to be given to at a minimum 50% of their clients seen each week.

**Timeline for compliance:** This will begin the week of 3/8/2021. Numbers towards compliance will be measured on an ongoing basis.

**Person responsible for action plan:** David McKay, Gary Goodrich

**DSAMH tracking by:** Pamela Bennett

## FY21 Recommendations:

- 1) *Holistic Care and Physical Health Documentation:* DBH has recently had staff trained as train-the-trainers for DIMENSIONS for nicotine cessation. However, a review of DBH charts indicated that documentation did not include whether an individual is using nicotine (five of nine charts) or had been offered nicotine cessation, identification of the primary care physician (nine of nine charts reviewed), or coordination across providers (six of nine charts). DSAMH recommends that the DBH review whether clinicians are adopting a whole health approach to care, and encourage providers to document these efforts. The DBH electronic health record could be updated to prompt the documentation of this type of information.
- 2) *Cultural and Linguistic Responsivity:* DBH has adopted a Cultural Competency Plan that includes a cultural competency committee and the development of a work plan. The initial short term goal is to “improve staff awareness of cultural competency by initiating cultural competency training” with twelve required training modules identified. In addition, DBH has revised intake procedures, provided guidelines for pronoun usage, expanded interpretive services and modified office decor to address the cultural representation in the building (specific to youth). DSAMH commends DBH for these efforts that include completing a Diversity Needs Assessment, and recommends the addition of bias sensitivity and microaggression training to the staff working with adult clients (already provided to the staff working with youth).

## FY21 Division Comments:

- 1) *Provision of Peer Support Services (PSS):* Heather Rydalch, Peer Support Program Manager, met with two Certified Peer Support Specialists (CPSSs), a CPSS supervisor, the Director of Journey House and a clinician. The FY21 Adult Mental Health Scorecard indicates that peer support services have increased 16.8% between FY19 and FY20. The staff discussed challenges related to serving clients during the pandemic, including struggling with burnout, scheduling transportation, and assisting individuals in treatment as they attempt to access technology (ie. smartphones) for telehealth. CPSSs reported that they have been successful in getting individuals to the doctor safely for Covid testing when the client is

symptomatic. *“Success is when a connection is made using peer support and then a client is willing to go see a doctor.”*

- 2) *Maternal Mental Health (MMH)*: DBH has received enhanced Maternal Mental Health training for four staff members, including two clinicians and two involved in prevention. The agency has been working collaboratively and accepting referrals from the Intermountain Healthcare Women’s Clinic in Layton. The MMH program includes Mindfulness training, postpartum therapy support, and a postpartum support group ([www.dbh.utah.gov/mental-health/motherhood/](http://www.dbh.utah.gov/mental-health/motherhood/)).
- 3) *Integration*: DBH and community health agencies appear to partner between Levels 2 and 3 of the six levels of Collaboration and Integration (Substance Abuse and Mental Health Services Administration). DBH is not co-located with physical health providers and screening tools are not shared. Behavioral and physical health providers have separate electronic health systems. DBH has portal access to Intermountain Health Care, University of Utah, and Davis Hospital for review of medical records, and maintains relationships for continuity of care with Tanner Clinic, Midtown Clinic and other primary care providers. Direct communication between physical health and mental health providers is done primarily by phone, with notes from psychiatric medication visits sent to the medical provider every six months. Medications for physical and mental health are bubble-packed together. Case managers or Peer Support assist with care coordination and appointment attendance.
- 4) *Participant Feedback*: Heather Rydalch, Peer Support Program Manager, met with nine Members at Journey House. Journey House provides transportation, supports Members searching for housing, and is primarily focused on recovery and employment. This includes transitional employment, independent employment, and supported employment that includes Individual Placement and Support to fidelity. Members described working at a range of jobs, both in Journey House and in the community. Comments included *“Since coming here my life has made a 180 degree turn for the better and I love all the staff here”*; *“I love Journey House! The staff has been so wonderful”*; *“This is a safe space where I can be myself with no judgement. Matt really cares and always keeps me busy and occupied”*; and *“Matt...cares and is hands on.”*
- 5) *Davis Receiving Center (RC)*: DSAMH commends Davis County and DBH on the development of a Zero Refusal Receiving Center with rapid screening and assessment, crisis stabilization, Peer Support, group therapy, medication-assisted treatment (MAT) and MAT induction tapering, Vivitrol inductions, and extended stabilization. Pre-booking citation diversion allows clients who engage in treatment for mental health and substance use disorders to avoid charges for misdemeanor offenses. Data from the first eleven months demonstrate that 74% of law enforcement drop off times were 5 minutes or less, and 86% of officer experience ratings were 10/10.
- 6) *Suicide Prevention*. DBH currently maintains a Zero Suicide Implementation Team. A formal Suicide Care Management Pathway is currently being reviewed, and clients identified as requiring suicide specific treatment may receive interventions that include Collaborative Assessment and Management of Suicidality (CAMS) protocols, Dialectical Behavioral Therapy (DBT)-based interventions, and/or a Crisis Response Plan. DBH has protocols in



place to reach out with supportive counseling when families and loved ones are impacted by suicide. For staff members affected by suicide, DBH also provides employee assistance program (EAP) resources, support from the Secondary Trauma Task Force, and weekly supportive employment staff meetings.

- 7) *Agency Resilience*: DBH has had a number of program leadership changes over the past year. It was identified that due to retirement and a small amount of turnover, nearly all of the mental health program leads are new since the prior monitoring year. This challenge is in addition to the understaffing caused by the pandemic. DBH has been able to provide high quality programs, develop a new facility (the Davis Receiving Center), and expand programming for adults while integrating the new program leaders.

## **Substance Use Disorders Prevention**

Becky King, Program Administrator, conducted the annual prevention review of Davis Behavioral Health on December 1st, 2020. The review focused on the requirements found in State and Federal law, Division Directives, and contracts. In addition, the review evaluated the services described in the annual prevention area plan and the data used to establish prevention priorities.

### **Follow-up from the Fiscal Year 2020 Audit**

#### **FY20 Major Non-compliance Issues:**

None

#### **FY20 Significant Non-compliance Issues:**

None

#### **FY20 Minor Non-compliance Issues:**

None

#### **FY20 Deficiencies:**

- 1) *EASY Compliance Checks*: The number of EASY Compliance Checks decreased from 168 in FY18 to 117 in FY19 respectively, which does not meet Division Directives. Davis County is required to increase the number of EASY Compliance Checks by one check each year.

The EASY Compliance checks decreased from 117 to 58 from the FY19 to FY20 respectively, which does not meet Division Directives. Davis County is required to increase the number of EASY Compliance Checks by at least one check each year.

***This issue is not resolved, which will be addressed in Deficiency #1 below.***

## **Findings for Fiscal Year 2021 Audit:**

### **FY21 Major Non-compliance Issues:**

None

### **FY21 Significant Non-compliance Issues:**

None

### **FY21 Minor Non-compliance Issues**

None

### **FY21 Deficiencies:**

- 1) The EASY Compliance checks decreased from 117 to 58 from the FY19 to FY20 respectively, which does not meet Division Directives. Davis County is required to increase the number of EASY Compliance Checks by one check each year.

### **County's Response and Corrective Action Plan:**

**Action Plan:** Utah Highway Safety discontinued the EASY compliance checks due to the COVID-19 pandemic. DBH prevention staff have had conversations with the law enforcement agencies in Davis County about resuming the checks and we'll continue to work closely with the departments to ensure completion.

**Timeline for compliance: May 1, 2021**

**Person responsible for action plan: Debbie Barley**

**DSAMH tracking by: Rebecca King**

### **FY21 Recommendations:**

- 1) **Substance Abuse Prevention Specialist Training (SAPST):** There are several new prevention staff that need to be trained in SAPST who are planning to attend the DSAMH on-line training in December. It is recommended that DBH follow through in sending their prevention to the SAPST.
- 2) **Community readiness assessments:** DSAMH recommends that DBH work with the ten identified communities within Davis County to complete a community readiness assessment by July 2022.

### **FY21 Division Comments:**

- 1) **Coalitions:** DBH's prevention efforts are currently focused on establishing, building and sustaining Communities that Care (CTC) coalitions throughout Davis County. The Communities that Care process guides communities through a process to prevent poor health and behavior outcomes for their youth, including e-cigarette, marijuana, and other drug use. At the end of FY20, DBH established a CTC in North Davis. Currently, there are three areas

in Davis County that are actively participating in the Communities that Care prevention process: North Davis (Clearfield, Syracuse, Clinton, West Point, and Sunset); Layton (Layton, Kaysville); and South Davis (Bountiful, Woods Cross, North Salt Lake, and West Bountiful). Each of these target communities has a full-time coalition coordinator. Coalition coordinators have finished the CTC training.

- 2) Risk and Protective Factors:** DBH has identified risk and protective factors to implement evidence-based strategies to target issues in their community. They have also worked with Davis4Health, which is the local community health improvement collaborative. They conducted a comprehensive community health assessment (CHA) in 2018 to identify the risk and protective factors for their community. Three priorities were selected: 1) suicide, 2) adverse childhood experiences & trauma, and 3) Opioids. Davis4Health partners prioritized three risk factors: 1) depressive symptoms, low commitment to school, and 3) family conflict.
- 3) Increased Capacity:** At the end of FY19, DBH had one part-time coalition coordinator. DBH applied for and received the Strategic Prevention Framework (PFS) and State Opioid Response (SOR) grant, which allowed DBH to increase their capacity in FY20 to a full-time coalition coordinator and another part-time coordinator. DBH staff have also worked with the Syracuse and Clearfield Police Chiefs to secure a percentage of beer tax dollars to pay a portion of the coalition coordinator's salary. DBH has applied for two additional grants in FY21 which has allowed them to hire two additional full-time coalition coordinators.

## **Substance Use Disorders Treatment**

Becky King, Program Administrator conducted the monitoring review on December 1st, 2020. The review focused on compliance with State and Federal laws, Division Directives, Federal Substance Abuse Treatment (SAPT) block grant requirements, JRI, DORA, Drug Court, scorecard performance and consumer satisfaction. The review included a document review, clinical chart review, and an interview with the clinical director and other staff members. Consumer satisfaction and performance were also evaluated using the Division Outcomes Scorecard, and the Consumer Satisfaction Scorecard.

### **Follow-up from Fiscal Year 2020 Audit**

#### **FY20 Minor Non-compliance Issues:**

- 1) The percent change in clients reporting tobacco use compared from admission to discharge moved from -7.6% to -33.0% from FY17 to FY18, which does not meet Division Directives.

The percent change in clients reporting tobacco used from admission to discharge moved from -7.6% to 3.9% from the FY19 to FY20 respectively, which meets Division Directives.

*This issue has been resolved.*

- 2) The Adult Consumer Satisfaction Survey Report shows that only 4.2% of these surveys were collected, which does not meet Division Directives. A minimum of 10% of surveys need to be collected to obtain accurate data results.

The FY20 Adult Consumer Satisfaction Survey Report shows that only 7.8% of these surveys were collected, which does not meet Division Directives.

*This issue has not been resolved, which will be addressed in the Minor Non-Compliance Finding #1 below.*

#### **FY20 Deficiencies:**

- 1) In FY19, 14.7% of the data was not collected for justice involved clients, which does not meet Division Directives.

In FY20, 4.5% of the data was not collected for justice involved clients, which meets Division Directives. The standard is to have less than 10% of data that is not collected.

*This issue has been resolved.*

### **Findings for Fiscal Year 2021 Audit:**

**FY21 Major Non-compliance Issues:**

None

**FY21 Significant Non-compliance Issues:**

None

**FY21 Minor Non-compliance Issues:**

***The Substance Use Disorder Outcome Measures Scorecard shows:***

- 1) The percent of clients using social recovery supports decreased from 17.0% to 9.4% respectively from FY19 to FY20, which meets Division Directives.

**Action Plan:**

- All SUD providers have been retrained on completing this.
- Each month, SUD Director and State Reporting Specialist review each discharge and transfer prior to submission to ensure accuracy

**Timeline for compliance: December 2020**

**Person responsible for action plan: Brett Bartruff**

**DSAMH tracking by: Rebecca King**

***The Consumer Satisfaction Survey Report shows:***

- 2) The Adult Consumer Satisfaction Survey Report shows that only 7.8% of these surveys were collected, which does not meet Division Directives.

**Action Plan:**

- Updated numbers are provided each time we get new counts/totals.
- Link is being sent out directly to consumers and the therapist asks in session if the client has completed the survey.
- Clients are given time to complete survey at the beginning or end of session if they have not
- SU residential clients are assisted with the use of facility computers in order to complete the survey; staff ensure all clients complete MHSP.
- Clinical staff in the Clearfield have worked with support staff to give clients the survey when they come in.
- Supervisors are reviewing regularly with each clinician to prompt consistent review of survey administration with the client.

**Timeline for compliance: January 2021**

**Person responsible for action plan: Brett Bartruff**

**DSAMH tracking by: Rebecca King**

- 3) The Youth Satisfaction (Family) Survey Report shows that only 6.2% of these surveys were collected, which does not meet Division Directives.

**Action Plan: Action Plan: The following steps have been implemented to improve MHSIP collection for FY22.**

- Updated collection numbers are provided weekly
- These are added to a spreadsheet that tracks progress toward the goal
- The spreadsheet is emailed to staff weekly along with reminders to ask clients/parents to complete. Therapists are also reminded of the ways that it can be completed:
  - Link emailed directly to the client/parent
  - Through tablet obtained from the front desk
- Day treatment staff are ensuring that these are completed by clients/parents participating in that program.
- The updated progress graphs are posted in the lobby (at the front desk) and in the staff break room.
- A sign is posted at the front desk asking clients/parents to complete the survey if they haven't already and that they can get something in return (candy or other incentive).
- The team as a whole will earn an incentive (ice cream party, lunch, etc.) if we meet our goal for the number completed.

As of March 9, 2021:

- Skills techs will be going through the therapists' schedules and contacting parents/clients to remind them about the survey and see if it has been completed. They will send the link immediately and/or complete with the family if it has not been done.
- Case managers will also be asking the families that they are working with.
- A report was pulled of MHSIPs completed by an assigned therapist (it's not 100% accurate and everyone knows this but it's okay). This was shared with the team and it was announced that the therapist with the most completed at the end of March will earn an additional incentive (gift card, etc.)

**Timeline for compliance: January 2021**

**Person responsible for action plan: Kim McComas**

**DSAMH tracking by: Rebecca King**

**FY21 Deficiencies:**

None

**FY21 Recommendations:**

- 1) **Youth Tobacco Cessation:** DBH maintains that they have been a little behind on tobacco cessation efforts for youth. Staff have been uncomfortable asking youth whether they are

smoking or vaping; however, DBH staff report that they are becoming more comfortable with this. It is recommended that DBH continue to work on asking youth if they are smoking and or vaping and provide tobacco cessation if needed.

#### **FY21 Division Comments:**

- 1) **Tobacco Cessation:** DBH has established a tobacco cessation committee that has developed a process for referrals and provides “Dimensions” for their adult program. Dimensions is an evidenced-based tobacco cessation program (EBP) designed to teach providers and peers the necessary information and skills to promote successful tobacco cessation within their organizations. DBH has been focusing on setting up new Dimensions groups this year.
- 2) **Medication Assisted Treatment (MAT):** DBH has expanded MAT to their community over the past year. MAT is actively being utilized in four different programs: (1) ***Opioid Community Clinic (OCC)***, where clients are screened for Opioid use (OUD) and alcohol use disorder. The OCC has four physicians and provides wrap around services. (2) ***Receiving Center***, where Suboxone is initiated for clients to help engage them in treatment. (3) ***Residential Addiction Treatment Program (RRC)***, where clients continue MAT as a part of their treatment. (4) ***Crisis Residential Unit***, where a large number of clients are treated for OUD’s and alcohol use disorders. DBH is using several forms of MAT, including Suboxone, Campral, Vivitrol, Sublocade, and other forms of MAT, except Methadone. They contract with Discovery House (Opioid Treatment Provider - OTP) for Methadone. DBH is also providing Suboxone for age appropriate kids (age 15 and older).
- 3) **Recovery Residence:** DBH recently set up a new recovery residence which is an apartment that houses four men and four women which provides recovery support. This program has been in place for the past year, which has been a positive support for their clients.
- 4) **Detoxification (Detox):** DBH is providing detox in their Receiving Center and the Crisis Residential Unit. Clients are screened to see whether they are eligible for social detox in their facility or need to be referred to the hospital. These programs have on-call doctors after hours who are available within 12 hours of admission. They also have 24 hour nursing services. The Receiving Center also has a Board Certified Psychiatrist, which helps with medical services and medication management.



## **Section Two: Report Information**

## Background

Utah Code Section 62A-15-103 outlines duties of the Division of Substance Abuse and Mental Health. Paragraph (2)(c) states that the Division shall:

- Consult and coordinate with local substance abuse authorities and local mental health authorities regarding programs and services,
- Provide consultation and other assistance to public and private agencies and groups working on substance abuse and mental health issues,
- Receive, distribute, and provide direction over public funds for substance abuse and mental health services,
- Monitor and evaluate programs provided by local substance abuse authorities and mental health authorities,
- Examine expenditures of any local, state and federal funds,
- Monitor the expenditure of public funds by local substance abuse authorities and mental health authorities,
- Contract with local substance abuse authorities and mental health authorities to provide a continuum of services in accordance with division policy, contract provisions, and the local plan,
- Assure that these requirements are met and applied uniformly by local substance abuse authorities and mental health authorities across the state,
- Conduct an annual program audit and review of each local substance abuse authority and mental health authority in the state and its contract provider in a review and determination that public funds allocated to by local substance abuse authorities and mental health authorities are consistent with services rendered and outcomes reported by them or their contract providers,
- Each local substance abuse authority and each mental health authority is exercising sufficient oversight and control over public funds allocated for substance abuse and mental health programs and services, and
- Other items determined by the division to be necessary and appropriate.

## Non-Compliance Issues, Action Plans and Timelines

This report is organized into individual sections, in which inadequacies will be identified and discussed. Inadequacies are assigned a level of severity based on the combined judgment of the monitoring team. In order to fully understand the degree of severity, a short discussion of the inadequacy levels follows.

A **major non-compliance issue** is non-compliance in contract requirements which affect the imminent health, safety, or well-being of individuals. In cases of non-compliance at this level, a written corrective action plan must be completed by the Local Authority immediately and compliance must be achieved within 24 hours or less.

It should be noted that in extreme cases where, in the professional opinion of the monitoring team, an elevated threat of imminent health, safety, or well-being of individuals exists, contract payments may be suspended indefinitely.

A **significant non-compliance issue** is either 1) non-compliance with contract requirements that do not pose an imminent danger to clients but that result in inadequate treatment or care that jeopardizes the well-being of individuals; OR 2) non-compliance in required training, paperwork, and/or documentation that are so severe or pervasive as to jeopardize the effectiveness of services and continued contract funding. This type of finding will also require the submission of a written corrective action plan in which the Local Authority identifies the steps it will take to rectify the issue and a time frame for accomplishing the correction. The due date for this submission shall be within 10 working days of receipt of the draft monitoring report by the Local Authority. Compliance must be achieved within 30 days of receipt of the draft monitoring report. Verification of the resolution may be accomplished in several ways including a follow-up visit, measurement during the next site review, a review of training documentation, a review of data submitted subsequent to the correction or a combination of these or any other method determined adequate to measure the resolution.

A **minor non-compliance issue** results when the reviewers identify a performance inadequacy that is relatively small in scope and does not impact client well-being or jeopardize funding. This type of finding will require the submission of a written corrective action plan in which the Local Authority identifies the steps it will take to rectify the issue and a time frame for accomplishing the correction. The due date for this submission shall be within 15 working days of receipt of the draft monitoring report by the Local Authority. Compliance must be achieved within 60 days of receipt of the draft monitoring report. Verification of the resolution may be accomplished in several ways including a follow-up visit, measurement during the next site review, a review of training documentation, a review of data submitted subsequent to the correction or a combination of these or any other method determined adequate to measure the resolution.

A **deficiency** results when the contractor is not in full compliance, but the deficiency discovered is not severe enough to be categorized as a non-compliance issue. A written corrective action

plan is required without a formal timeline. However, the monitoring team may request action to fix the problem by a given date.

A **recommendation** occurs when the contractor is in compliance. The Division is simply making a best practice or technical suggestion. The contractor is encouraged to implement the suggestion but not required.

In rare instances, a non-compliance issue from a previous year may continue unresolved at the time of the monitoring site visit. A recurring non-compliance issue will be prominently displayed in the current monitoring report and will require special attention by the Local Authority to ensure its immediate resolution.

*Corrective Action Requirements:* It is the responsibility of the Local Authority to develop a corrective action plan sufficient to resolve each of the noncompliance issues identified. These corrective action plans are due within 15 working days of the receipt of this report. The Division of Substance Abuse and Mental Health may be relied upon for technical assistance and training and the Local Authority is encouraged to utilize Division resources. Each corrective action plan must be approved by Division staff and should include a date by which the Local Authority will return to compliance. This completion date and the steps by which the corrective action plan will return the Local Authority to contract compliance must be specific and measurable.

Submit the corrective action plan inside of the provided box after each finding or deficiency. Please do not make any edits outside of these boxes.

*Steps of a Formal Corrective Action Plan:* These steps include a formal Action Plan to be developed, signed and dated by the contractor; acceptance of the Action Plan by the Division as evidenced by their signature and date; follow-up and verification actions by the Division and formal written notification of the compliance or non-compliance to the contractor.

*Timeline for the Submission of the Action Plan:* This report will be issued in DRAFT form by the Division of Substance Abuse and Mental Health. Upon receipt, the Center will have five business days to examine the report for inaccuracies. During this time frame, the Division requests that Center management review the report and respond to Kelly Ovard if any statement or finding included in the report has been inaccurately represented. Upon receipt of any challenges to the accuracy of the report, the Division will evaluate the finding and issue a revision if warranted.

At the conclusion of this five day time frame, the Center will have 10 additional business days to formulate and submit its corrective action plan(s). These two time deadlines will run consecutively (meaning that within 15 working days of the receipt of this draft report, a corrective action plan is due to the Division of Substance Abuse and Mental Health).

The Center's corrective action plan will be incorporated into the body of the report when issued.


## Signature Page

We appreciate the cooperation afforded the Division monitoring teams by the management, staff and other affiliated personnel of Davis Behavioral Health and for the professional manner in which they participated in this review.


If there are any questions regarding this report please contact Kelly Ovard at 385-310-5118.

The Division of Substance Abuse and Mental Health

Prepared by:

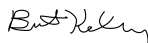
Kelly Ovard  Date 03/15/2021  
Administrative Services Auditor IV

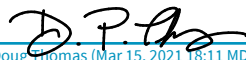
Approved by:

Kyle Larson  Date 03/15/2021  
Administrative Services Director

Eric Tadehara  Date 03/15/2021  
Eric Tadehara (Mar 15, 2021 15:06 MDT)  
Assistant Director Children's Behavioral Health

Kimberly Myers  Date 03/15/2021  
Kim Myers (Mar 15, 2021 16:30 MDT)  
Assistant Director Mental Health

Brent Kelsey  Date 03/19/2021  
Assistant Director Substance Abuse

Doug Thomas  Date 03/15/2021  
Doug Thomas (Mar 15, 2021 18:11 MDT)  
Division Director

## Attachment A

# UTAH DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

## Emergency Plan Monitoring Tool FY21

**Name of Local Authority:** Davis Behavioral Health

**Date:** 12/7/2020

**Reviewed by:** Robert H. Snarr, MPA, LCMHC  
Geri Jardine

<i>Compliance Ratings</i>				
Y = Yes, the Contractor is in compliance with the requirements.				
P = Partial, the Contractor is in partial compliance with requirements; comments provided as a suggestion to bring into compliance.				
N = No, the Contractor is not in compliance with the requirements.				
Monitoring Activity	Compliance			Comments
	Y	P	N	
<b>Preface</b>				
Cover page (title, date, and facility covered by the plan)		X		Needs date
Signature page (with placeholders to record management and, if applicable, board of directors' approval of the plan and confirmation of its official status)			X	Need signature page on plan (with placeholders to record management and, if applicable, board of directors' approval of the plan and confirmation of its official status)
Title page (with placeholders to record the dates that reviews/revisions are scheduled/have been made)			X	Need place for revisions/reviews are noted on the document
Record of changes (indicating when changes have been made and to which components of the plan)			X	Need place to identify changes to the plan, made by whom, and date of change
Record of distribution (individual internal and external recipients identified by organization and title)			X	Need distribution record
Table of contents			X	Need table of contents
<b>Basic Plan</b>				
Statement of purpose and objectives	X			
Summary information	X			
Planning assumptions	X			
Conditions under which the plan will be activated	X			
Procedures for activating the plan	X			
Methods and schedules for updating the plan, communicating changes to staff, and training staff on the plan			X	Need to identify the methods for updating the plan, communicating changes and how staff are trained.
<b>Functional Annex: The Continuity of Operations (COOP) Plan to continue to operate during short-term or long-term emergencies, periods of declared pandemic, or other disruptions of normal business.</b>				
List of essential functions and essential staff positions			X	Need to list essential functions and staff positions (i.e., include org chart)
Identify continuity of leadership and orders of succession			X	Need to identify continuity of leadership and orders of succession (i.e., include org chart)

Identify leadership for incident response			X	Need to identify incident response
List alternative facilities (including the address of and directions/mileage to each)			X	Need to include alternative facilities available, if needed
Address recovery and maintenance of client records			X	Need to address recovery/maintenance of client records
Communication procedures with staff, clients' families, the State and community			X	Need to identify coordination efforts with the State, community and clients' families.
Procedures that ensure the timely discharge of financial obligations, including payroll.			X	Need to address procedures to ensure financial obligations will be continued
<b>Planning Step</b>				
Disaster planning team has been selected, to include all areas (i.e., safe/security, clinical services, medication management, counseling/case management, public relations, staff training/orientation, compliance, operations management, engineering, housekeeping, food services, pharmacy services, transportation, purchasing/contracts, medical records, computer hardware/software, human resources, billing, corporate compliance, etc.)			X	Need to identify who is on the disaster planning team and representing which area.
The planning team has identified requirements for disaster planning for Residential/Housing services including: <ul style="list-style-type: none"> <li>• Engineering maintenance</li> <li>• Housekeeping services</li> <li>• Food services</li> <li>• Pharmacy services</li> <li>• Transportation services</li> <li>• Medical records (recovery and maintenance)</li> <li>• Evacuation procedures</li> <li>• Isolation/Quarantine procedures</li> <li>• Maintenance of required staffing ratios</li> <li>• Address both leave for and the recall of employees unable to work for extended periods due to illness during periods of declared pandemic</li> </ul>			X	Need to specify how these functions will be provided in the event of a disaster

DSAMH is happy to provide technical assistance.












# Final Report FY21 Davis Audit

Final Audit Report

2021-03-19

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